MEDPAC Medicare Payment Advisory Commission

STATEMENT

Statement for the Record

March 10, 2009

Committee on Ways and Means

In December 2008, Milliman, Inc conducted an analysis on behalf of the American Health Insurance Plans, American Hospital Association, Blue Cross and Blue Shield, and Premera Blue Cross, which argues that Medicare pays too little and that as a result, private payers have to pay well above costs to keep hospitals solvent. In other words there is a cost-shift from Medicare to the private sector. MedPAC analysis published in the March 2009 *Medicare Payment Policy* Report to Congress calls this argument into question.[1]

The traditional "cost-shift" argument starts with the assumption that costs are largely outside hospitals' control, or immutable. When external forces cause costs to be higher than Medicare prices, hospitals ask private insurers to increase their payment rates to cover the losses on Medicare patients. Hospitals argue that cost shifting is needed to maintain financial viability. Recently, Milliman implied that if Medicare paid hospitals more, hospitals would obtain less from private insurers and insurers would lower premiums for employers and consumers. If this Milliman hypothesis is valid, it would predict that if Medicare were to increase its payment rates, hospitals would accept lower payment rates from private insurers. While hospitals plead to insurers that they are under financial stress due to "cost shifting" and need payment increases from private insurers, the degree to which private insurer rates are driven by this plea from hospitals is an empirical question.

In contrast, the MedPAC has argued that high profits from non-Medicare sources permit

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hospitals to spend more. The causal chain is as follows: A hospital's market power relative to insurers, payer mix, and donations determines its level of financial resources. When financial resources are abundant, hospitals spend more and increase their costs per unit of service. High costs by definition lead to lower Medicare margins because costs do not affect Medicare revenues (which are based on predetermined payment rates). Therefore, when costs increase, Medicare margins decrease. In other words, income affects spending and in turn costs per unit of service. Hence, if Medicare were to increase its payment rates, it is not reasonable to think that hospitals with market power will voluntarily lower the prices charged to insurers and reduce their revenue. Instead, hospitals might spend some or all of that revenue, resulting in higher costs.

In MedPAC's March 2009 report, we explore an empirical analysis of this hypothesis. First, if the MedPAC argument is correct we would expect hospitals under high fiscal pressure (i.e., low private margins; low endowments) to have lower costs than low fiscal pressure hospitals (with high private margins and high endowments). The data supports this expectation. Using 2007 data (Table 1), we find that hospitals under pressure have lower costs per discharge ($5,800) than hospitals under little fiscal pressure ($6,400). In fact, this should not be a surprise for those who recall the managed care experience in the 1990s – managed care plans exerted pressure on hospital costs, and costs grew much more slowly.

Table 1. High financial pressure leads hospitals to constrain costs

	Level of financial pressure 2002 to 2006	
2007 Financial characteristics (medians)	High pressure	Low pressure
Standardized cost per discharge		
All hospitals	$5,800	$6,400
Non-profit hospitals	5,700	6,500
For-profit hospitals	5,900	6,000
Annual growth in cost per discharge 2004 to 2007	4.8%	5.0%
Non-Medicare margin (private, Medicaid, uninsured)	–2.4%	13.5%
Overall Medicare margin	4.2	–11.7

Note: High pressure hospitals had median non-Medicare profit margins of 1 percent or less from 2002 to 2006 and net worth would have grown by less than 1 percent per year from 2002 to 2006 if the hospital's Medicare profits had been zero. Low pressure hospitals had median non-Medicare margins were greater than 5 percent from 2002 to 2006 and a net worth that would have grown by more than 1 percent per year if its Medicare profits were zero. Standardized costs are adjusted for case mix, wage index, outliers, transfer cases, interest expense, and the effect of teaching and low-income Medicare patients on costs per discharge.

Source: MedPAC analysis of Medicare Cost Report and claims files from CMS available as of August, 2008.

The second empirical question is whether the hospitals with high Medicare losses tend to have financial resources that allow high costs or if they tend to be financially troubled facilities that require higher private rates to keep them afloat. The data indicate that the hospitals with the largest Medicare losses tend to be in better financial shape than other hospitals. From 2002 to 2006, hospitals with low Medicare margins had median total (all payer) margins of 4.6 percent compared with 3.4 percent for hospitals with high Medicare margins (Table 2). In addition, net worth for the high-cost hospitals rose by 17 percent from 2004 to 2006 compared with a 14 percent rise for low-cost hospitals.

Table 2. Revenue drives costs

	Overall Medicare profit margin in 2007		
	<-10%	-10% to 0%	>0%
Financial characteristics (medians)			
Standardized costs (2007)	6,900	6,100	5,500
Number of hospitals	1,138	789	964
Medicare margin (2007)	-20.0%	-5.1%	7.6%
Median total margin in 2004-2006*	4.6%	3.8%	3.4%
Percent change in net worth 2004-2006	17%	15%	14%

Total margin refers to total revenue from all sources (including Medicare) less total expenses, divided by total revenue. *When comparing the highest cost to the lowest cost groups, the difference in median total margins from 2004 to 2006 is statistically significant (p=.0003) using a Wilcoxon rank test. The difference in equity growth rates is not statistically significant (p=.088).

It may appear odd that hospitals with high costs have high total profit margins. In a typical industry, high profits are not associated with high unit costs. The hospital industry is different, however, because of the dominance of nonprofit providers, the influence of payer mix, hospital and insurer market power, and the effect of investments and donations on hospital finances.

One final point, people might reasonably be concerned that fiscal pressure results in lower costs and possibly lower quality. To look at this - we asked if there were hospitals that consistently control their costs and have at least average quality. We identified over 300 Medicare hospitals that have performed well on a mix of quality measures and costs over a three year period (2004-2006). Using 2007 data we compared them to all other hospitals in Medicare. The group had lower costs and consistently out performed the other hospitals on a range of mortality measures.

To be clear – not all low cost hospitals have high quality, but there are hospitals that consistently control their costs yet perform outperform other hospitals on quality measures.

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[1] For a longer discussion of this MedPAC analysis, please refer to pages 57 to 67 in *Medicare Payment Policy*, MedPAC's March 2009 Report to Congress, available at www.medpac.gov.